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Guidelines for Promoting Decentralization of Health Systems in Latin America

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INTRODUCTION

These guidelines are designed to help health reformers interested in the decentralization of health systems.[1] Health sector officials in ministries of health at all levels, representatives of donor agencies, consultants giving technical assistance, and major private sector stakeholders will be interested in these guidelines. In addition, officials from ministries of finance, planning, and internal affairs, especially those responsible for local governments, we hope will find these guidelines useful.

These guidelines draw on general literature and experience of many experts in decentralization. However, in addition to the "rule of thumb" information based largely on anecdotal experience, these guidelines draw heavily on systematic applied research studies of decentralization in Chile, Bolivia, and Colombia. The lessons from these experiences suggest *ways of designing and implementing decentralization so that it might have the best chance to improve a health system*.

In the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world. Decentralization, often in combination with health finance reform, has been promoted as a key means of improving health sector performance and promoting social and economic development (World Bank 1993). The preliminary data from the field, however, indicate that results have been mixed, at best.

Within the health sector, the *arguments in favor of decentralization* tend to show how decentralization can achieve other goals of the health sector such as efficacy, equity, efficiency, quality, financial soundness, and local preference. It is often argued that *local officials have better knowledge of local conditions* and if they are given the *flexibility to manage the way they use human resources, organize the services and purchase local supplies* that they will make better decisions than far off bureaucrats. It is assumed that this more immediate knowledge and flexibility will result in more efficient and effective decisions. Also with *local accountability* it is expected that decentralization will bring higher quality because the local population will demand it. However, there are *reasons to fear that decentralization will not achieve these objectives* and indeed may make things worse. It is often feared that decentralization will bring *greater inequalities because richer communities can assign more of their own resources to health care* than can poorer communities. Within communities it is also feared that *local elites will make decisions that favor their interests* rather than the interests of the broader population, especially the poor. In addition, local pressures to *use public facilities for patronage jobs* might increase the inefficiency rather than improve it. On quality, *local accountability may favor patient satisfaction but not necessarily improve the clinical quality* that may require supervision from those with higher technical skills.

[1] The author would like to thank Riitta-Liisa Kolehmainen-Aitken, for her insightful comments on an earlier draft of these guidelines.

It is important to recognize that there is no strong consensus on the impact of decentralization—advocates and detractors—are both probably wrong. We have some evidence to bring to bear on these issues and have reason to believe that it is not so much decentralization itself but how decentralization is designed and implemented, that will make the difference in equity, efficiency, quality and financial soundness. These guidelines are based on findings of applied research studies in Chile, Colombia, and Bolivia that were implemented by local research teams under the direction of Thomas Bossert of the Data For Decision Making Project at the Harvard School of Public Health.[2]

[2] The author would like to thank all those involved in the research projects including Osvaldo Larrañaga, Antonio Infante and Consuelo Espinosa in Chile; Fernando Ruiz Mier, Scarlet Escalante, Marina Cardenas, Bruno Giussani, and Katherina Capra in Bolivia; Ursula Giedion, Jose Jesus Arbelaez, Alvaro Lopez and Luis Gonzalo Morales in Colombia and Mukesh Chawla, Joel Beauvais and Diana Bowser who supported various country projects from Harvard. He also thanks the many Chilean, Colombian, and Bolivian officials and observers who provided support through interviews and documents. In addition, the unfailing support of USAID officials, Kathleen McDonald, Carl Abdou Rahmaan, Karen Cavanaugh, and Carol Dabbs was essential to this project. For a summary of the results see Thomas Bossert, *Decentralization of Health Systems in Latin America: A Comparative Study of Chile, Colombia, and Bolivia*. Boston: Data For Decision Making Project, Harvard School of Public Health 2000. This report as well as the country reports will be made available at www.hsph.harvard.edu/ihsg/publications.html.

GUIDELINES

WHAT ARE THE BASIC CHOICES IN DECENTRALIZATION?

There are two principle issues of design for decentralization. The first is to identify which institutions are to take on the new authority and responsibilities of decentralization. The basic choices are to:

- "deconcentrate" authority and responsibility to the regional and/or district offices of the Ministry of Health
- "devolve" authority and responsibility to the state, province and/or municipal governments
- "delegate" authority and responsibility to another semi-autonomous agency such as a separate board of health, health fund, or superintendencia.

In Chile, Bolivia, and Colombia, the governments have devolved authority and responsibility over health to the municipalities; therefore, these guidelines are oriented toward design and implementation of "devolved" health systems.

Our research does not inform us about the advantages and disadvantages of these different choices about the institutional "home" of decentralized authority. However, it is likely that it is easier to shift responsibility and authority within the Ministry of Health than it is to devolve or delegate. This means that central authorities can control the outcome more easily, but it also allows for easy recentralization and provides less incentive for the decentralized units to develop their skills in decision making. It is also likely to provide less incentive for responsiveness to local social and electoral participation.

The second set of design issues is about how much choice should be allowed to local decision-makers. For this we have developed a "decision-space" map to define the options of ranges of choice (from narrow to wide) over different functions (finance, service delivery, human resources, targeting, and governance).

The following table outlines the kinds of design choices that are available.

Table 1. Decision-Space Functions

Decision-Space Functions	Description of Functions
Finance and Expenditure Functions	
Revenue Sources	Choices about where sources come from: i.e. Will local authorities be allowed to assign own source revenue to health?
Allocations of Expenditures	Choices about how to allocate funds: i.e. Will local authorities be allowed to assign funds to different priority programs? Hospitals vs. primary care?
Fees	Choices about local charges: i.e. Will local authorities be allowed to set fees at all, and if so are they allowed to determine the levels and change them?
Service Organization Functions	
Hospital autonomy	Will local authorities grant hospitals autonomy and select the degree of autonomy allowed?
Insurance Plans	Will local authorities create, manage, and regulate local health insurance plans?
Payment Mechanisms	Will local authorities select different means of paying providers? E.g. per capita, salary or fee for service.
Required Programs and Services	To what degree will the central authority define what programs and services the local health facilities have to provide?
Service Standards	To what degree will the central authority define service standards, such as quality standards for facilities?
Vertical Programs and Supplies and Logistics	Are vertical programs continued under the control of central authorities or are they transferred to local control? Are drugs and other supplies provided by central authorities or do they become the responsibility of local authorities?
Human Resources Functions	
Salaries	Will local authorities be allowed to set different salary levels? Will they be allowed to determine bonuses?
Contracts	Will local authorities be allowed to contract short-term personnel and set contract terms and compensation levels?
Civil Service	Will local authorities be allowed to hire and fire the permanent staff without higher approvals? Will staff able to be transferred by local authorities?
Access Functions	
Access Rules	Will local authorities decide who has access to facilities and who is covered by insurance?
Governance Functions	
Governance Rules	Are local officials accountable to the electorate? Will local authorities have choices about: Size and composition of hospital boards? Size and composition of local health offices? Size, number, composition and rule of community participation?

WHAT ARE GOOD CHOICES FOR DECISION SPACE?

The following Decision-Space Map shows how three Latin American countries have defined their decision spaces for the different functions.

Table 2. Comparative Decision Space: Current Ranges of Choice

Functions	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of Revenue		Colombia Chile Bolivia	
Expenditures		Colombia Chile Bolivia	
Income from Fees	Chile Bolivia	Colombia	
Service Organization			
Hospital Autonomy	Colombia Chile	Bolivia	
Insurance Plans	Colombia Chile Bolivia		
Payment Mechanisms		Colombia Chile Bolivia	
Required Programs & Norms	Colombia Chile Bolivia		
Vertical Programs, Supplies and Logistics		Colombia Chile Bolivia	
Human Resources			
Salaries	Colombia Chile Bolivia		
Contracts		Colombia Bolivia	Chile
Civil Service	Colombia Chile Bolivia		
Access Rules			
Targeting	Colombia Chile Bolivia		
Governance Rules			
Local Governance			Colombia Chile Bolivia
Facility Boards	Colombia Bolivia	Chile	
Health Offices	Colombia Bolivia	Chile	
Community Participation	Bolivia		Colombia Chile
Total Decision Space: Colombia Chile Bolivia	8 7 9	6 6 6	2 3 1

As can be seen by the decision space map in Table 2, many functions are still in the narrow range of choice, meaning that the central authorities define these choices. However, there are a significant number in the moderate range of choice and for a few functions, the local authorities are granted a wide range of choice. The tendency is for allocation, contracting, and governance decisions to be wider than for service delivery organization, targeting, and salaried civil service rules. In several cases, wide ranges of choice were initially allowed—over allocations of expenditures and over human resources—but these choices were later reduced. Wide choice over human resources has brought political backlash from the unions and professional associations. Wide choice over allocation of expenditures has led central authorities to impose earmarks and other restrictions.

It is important to note that there are strong political forces that may produce a tendency over time to narrow choice over key functions. In Chile, the initial wide choice over human resources was later restricted by the Statute of Primary Health Care Workers. In Colombia, the initial choice allowed by Law 60 was restricted by Law 100, which assigned a percent of local funding to insurance plans. In Bolivia, the introduction of the Seguro Materno Infantil, earmarked a percentage of local funding for specific expenditures and reduced choice over fee collection. These shifts focused on the major areas of control—allocation of expenditure and human resources. In the case of restrictions on human resources in Chile, they were the result of political pressure by the health professionals. In the cases of restricting choice on expenditures, the initiatives were from the Ministries of Health attempting to force local governments to allocate funding to national priorities.

If these experiences are to be a guide for more effective decentralization, then the following Table provides useful suggestions for designing other decentralization processes. There are no strict rules or indicators for the ranges of choice allowed for each function; however we have included in Annex I suggestive details of the range of choices in each of the countries studied. A blank Decision-Space Map is presented in Annex II.

Table 3. General Range of Choice

Functions	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of Revenue		***	
Expenditures		***	
Income from Fees	***		
Service Organization			
Hospital Autonomy	***		
Insurance Plans	***		
Payment Mechanisms		***	
Required Programs & Norms	***		
Vertical Programs, Supplies and Logistics		***	
Human Resources			
Salaries	***		
Contracts		***	
Civil Service	***		
Access Rules			
Targeting	***		
Governance Rules			
Local Accountability			***
Facility Boards	***		
Health Offices	***		
Community Participation			***
Total Decision Space	9	5	2

*** Suggested Range of Choice

HOW TO IMPROVE EQUITY OUTCOMES OF DECENTRALIZATION?

Central authorities usually assign resources to the decentralized units—either to the devolved authorities (municipalities, states, provinces) or the deconcentrated districts and regions of the Ministry of Health. For the devolved authorities, central funds are called "intergovernmental transfers" and are usually allocated to municipalities according to a formula that includes population size and adjustments for historical budgets, proportion of rural population, and other special situations. For the deconcentrated units of the Ministry these funds are usually the direct budget assigned to districts or regions. Our cases did not include deconcentrated systems therefore this guide will focus on devolved decentralization.

It is often argued that devolved decentralization can increase inequalities, mainly because wealthier municipalities can allocate more of their own source revenues to health care than can the poorer municipalities. Contrary to this argument, our studies tend to show that decentralization can reduce inequalities in per capita allocations.[3] While we found a significant difference in the allocations of wealthy and poor municipalities in Chile and Colombia, we also found that the gap between rich and poor was narrowing over time after decentralization. We found that poorer municipalities were able to contribute enough of their own source revenues to reduce the gap.

In Chile the local capacity to pay for health was strengthened by **an innovative equalization fund** that could be a model for other countries as they design their decentralization programs. The Chilean Municipal Common Fund took a portion of the own-source taxes and other revenues from the wealthiest municipalities (up to 60% of those revenues) and put them into an equity fund that reallocated the funds to the rest of the municipalities based on a per capita and municipal poverty formula. This equalization fund reduced the income differences among municipalities significantly. (the Gini coefficient declined from .45 to .30). [4]

This fund may not be necessary to produce equity of per capita allocations to health, but it is a good example of a mechanism for reallocations. Alternatives are to **reassign central funds with a formula based on municipal capacity to raise revenues**. This mechanism however should be adjusted so that richer municipalities still have an incentive to allocate their funding to health. If not, these municipalities may have an incentive to be "fiscally lazy" and reduce their funding with the expectation that the central government will pick up the difference.

Another mechanism used by Colombia and Bolivia is to **require a minimum percentage allocation of central government transfers that must be used for health programs**. In Bolivia, municipalities are required to allocate to a defined package of health services at least 3.2% of the funding that comes from the central budget. Since the funding is provided to the local communities based on a per capita formula, this mechanism improves the equity of allocations.[5]

A third mechanism is **matching grants** that central authorities can use to encourage local authorities to assign funds to priority programs and to priority populations. In order to improve equity, this mechanism can be adjusted so that poor communities are required to provide only a minimum counterpart funding, while wealthier communities have higher requirements. It is important for central authorities to retain a significant budget in order to have the funds to provide matching grants.

[3] We are able only to analyze this indicator of equity and not more specific issues of equity of access, nor were we able to assess equity in terms of access or allocation to those in most health need.

[4] For detailed description of this fund see: Thomas Bossert, Osvaldo Larrañaga, Antonio Infante, Joel Beauvais,Consuelo Espinosa, Diana Bowser, *Applied Research on Decentralization of Health Systems in Latin America: Chile Case Study*, Boston: Data For Decision Making Project, Harvard School of Public Health, 2000

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HOW TO IMPROVE EFFICIENCY?

Allocative Efficiency

Allocative efficiency refers to how well local decision makers allocate funds to the appropriate services. In simple terms, it might ask if local decision makers assign more resources to the most effective public health services or do the assign more to hospitals and curative care.

An important issue often raised about decentralization is whether it improves or detracts from priority primary health care programs. We still do not have sufficient data to evaluate immunization programs and other disease specific programs, however, evidence from Colombia suggests that municipalities can provide **increasing per capita funding for prevention and promotion** and that the gap between rich and poor municipalities can also narrow over time.

One of the mechanisms that appears to contribute to this improvement in allocations to promotion and prevention is the **forced assignment of a specific percentage of revenues from central government transfers**. The Colombian fiscal system earmarks 5% of the municipal revenue from one intergovernmental transfer to cover preventive and promotion activities.[6]

There is growing, if so far not completely compelling, evidence from other studies, that highly centralized vertical programs and drug supply systems become disrupted, ineffective and inefficient if responsibility for these activities is quickly transferred to local authorities, without sufficient funding and technical assistance. While this phenomenon may be temporary and resolvable by local learning and funding, it is likely that **special programs to train local officials and provide additional support for drug supply and vertical programs would help the transition**. An alternative is for the central authorities to retain control over these activities, a program that may solve the problem but may make integrated services more difficult.

Technical Efficiency

Technical efficiency asks whether decision-makers are able to increase the outputs for the same level of inputs or able to reduce inputs for the same level of outputs.

It is not clear whether decentralization has been able to achieve this improvement. Two of the major ways of improving efficiency -- changing the mix of service delivered and changing the human resources mix -- were the areas where decision space was usually most narrow.

Where municipalities are able to **increase contract personnel** they may have been able to increase technical efficiency. In Colombia municipalities that were certified to have greater control over their resources were contracting more of their workforce. Having this flexibility of

[6] In Zambia, where Harvard is also studying decentralization under the PHR project, the local districts are given a maximum and minimum range of allocations of expenditures for the amount assigned to hospitals, primary care clinics and the district office, as well as ranges for drugs, other supplies, transportation, and personnel.

local management, rather than being restricted by civil service rules may offer opportunities to improve the mix of human resource in-puts so as to improve efficiency. However, increased local choice, without some rules to encourage merit hiring, may result in patronage hiring which is unlikely to improve efficiency.

HOW TO IMPROVE QUALITY?

It is hard to evaluate the relationship between decentralization and quality of heath services. None of our studies had clear evidence. Perceptions of stakeholders in Colombia and Bolivia suggest that decentralization improved services. However, surveys of public opinion showed high levels of dissatisfaction with health services in Chile after the reforms. Other studies tended to find little difference in quality of services between those supervised by the Ministry of Health and municipal facilities. We therefore can make no clear recommendation to guide decentralization toward improved quality of services, other than to suggest that the programs of quality improvement and accreditation that are implemented under both centralized and decentralized systems are likely to be needed.

LOCAL CONDITIONS

The local characteristics of municipalities also appear to be important determinants of the effectiveness of decentralization, especially in countries with weak institutional development and limited enforcement capacity, like Bolivia.

Decentralization appears to work better when the local authorities, especially the mayors, know and respect the laws and regulations of decentralization and take their own initiatives in the health sector. While health sector may not have much influence over local elections, it may be important to educate all new local officials in the requirements of the laws and to clearly define for them what their decision space is and what kinds of innovations they may want to initiate. This might mean a **formal training program by the Ministry of Health to be held after each election period**, or it could be a training task that the Ministry requires of all local health officials to be given to their mayors after inauguration.

Effective decentralization may also depend on good relations among the mayor, local health providers and the local community. On-going **training programs that encourage consensus building and conflict resolution** at the community level may improve the effectiveness of decentralization.

INFORMATION SYSTEMS

It is also important to develop effective monitoring systems so that central authorities can assess the effects of local decisions and be sure that national objectives are being pursued. At minimum the information system should have detailed financial information on income—from all sources -- and on expenditures. Data on utilization, preferably broken down by priority programs such as pre natal visits and immunizations, is also needed. The local entities should have a clear population base of beneficiaries so that per capita expenditures and per capita utilization can be assessed. In addition, it would be useful to have routine information on personnel—by profession and by civil service vs. contract. Indicators of quality of service—

such as prevalence of preventable diseases and intra hospital infection rates—would also be useful.

The information system should also make available to the central authorities and to other local officials, the innovations that localities make so that effective new programs can be replicated. One of the advantages of decentralization is this local experimentation that may produce new and more effective service delivery.

CONCLUSION

Both the advocates and the detractors of decentralization are probably wrong. A thoughtfully designed process of decentralization is not likely to radically improve a health system, nor is it likely to severely disrupt the system. We have evidence that a well-designed decentralization can improve equity of allocations and may have other positive effects such as increased funding of promotion and prevention. Its influence over efficiency and quality is not as clear. The trend toward increased decentralization appears to be a universal and multi-sectoral process that the health sector is probably going to have to accommodate to in some manner. It will be important for major actors in the health sector to assist in the design of more effective mechanisms of decentralization so that the positive effects are forthcoming. These guidelines suggest some mechanisms which can be effective in the design and implementation of decentralization:

- decision space changes,
- equalization funds,
- allocation formulae for intergovernmental transfers
- allocation rules that earmark funding for specific purposes, and
- training exercises for local authorities and communities.

In addition, it is clear from the studies that the central authorities need improved monitoring systems in order to assess and evaluate how well the local authorities are achieving the goals and objectives of national policy. Only with continual monitoring can the central authorities adjust the decision space and provide additional incentives to encourage local authorities to make appropriate choices. This is also a two-way street in that effective local innovations can be disseminated to other local officials and replicated.

ANNEX I. "DECISION-SPACE" CHOICES BY FUNCTION

Decision-space maps show some similarities as well as significant differences among the three countries studied (Chile, Bolivia, and Colombia). First, there is in general only a moderate range of choice allowed to local municipalities. No municipalities had a full range of choice over key functions of finance and human resources. Significant restrictions remained under the control of the central government.

FINANCE FUNCTIONS

The finance functions are of particular importance in decentralization. The choice to control revenues allocated to the health sector, expenditures within the health sector and to set and retain fees are major instruments of local control. The choice to control revenues is a major means by which local governments can exercise their choice over whether health is a priority compared to other local activities like education, civic facilities, and roads. It is also a means by which wealthier communities can assign more resources than poorer communities, thus contributing to inequities in ways that centralized allocations may not. This choice was quite wide in Bolivia after the passage of the Popular Participation Law that allowed municipalities to assign a wide range of their intergovernmental transfers to health (0-60%). This choice was later restricted by the Maternal and Child Health Insurance Law, which earmarked 3% of these funds specifically to supplies and equipment for the benefits package for mothers and children. In Chile, allocations to the health sector were formally made by a fee for service tariff set by the central authorities, but there was a ceiling to these fees -- usually exceeded by utilization -- and that ceiling was set by informal negotiations between municipalities and the Ministry of Health. This negotiation gave the local authorities some range of influence over this source of funding. In addition, local municipalities were allowed freely to assign their own source revenues to health.[7] In Colombia, the municipalities received two sources of intergovernmental transfers, a municipal direct transfer and a transfer through the Departments (*situado fiscal*), both of which had percentage ranges that were earmarked to health. The municipalities had some choice within the percentage ranges and they could assign their own source revenues to health.

Choices about expenditures of the health budget are also important part of decentralization. Managing health expenditures can allow local managers to make choices that respond to local conditions and preferences and may also allow for more technically efficient choices since local managers may know more about local staff, local input markets, and other factors. Chile initially granted local municipal authorities the widest choice on this function, however, this choice was restricted later by requiring expenditures to cover staff that was protected by the new Human Resources Statute. Bolivia allowed municipalities to assign health resources within a wide percentage range, but later restricted this choice through the earmarked assignment of health funds to the maternal and child benefits package. In Colombia, certification granted municipalities control of expenditures, which was lacking in non-certified municipalities. Department authorities controlled most expenditures in uncertified

[7] In Chile, wealthier municipalities had to assign a significant portion of their revenues to a horizontal equalization fund (Municipal Common Fund) that reduced their choice over assignment of own source revenues.

municipalities. In all three countries, local own source revenues assigned to health could be expended without central restrictions.

Control over setting and retaining fees is also an important financing function. It is often argued that retention of fees at local levels increases the incentives for local managers to collect fees and to be more responsive to consumer demand. Control over setting fees also allows local managers to be more responsive to local market conditions. Bolivia and Colombia had a moderate range of choice over fees—either by an explicit range or by requirement that Ministry of Health approve local fee schedules. However, in Bolivia this changed when the Maternal and Child Insurance required that the basic package of services be provided free of charge. Chile required that all primary health care services be provided free of charge.

SERVICE ORGANIZATION FUNCTIONS

The ability of local governments to allow their facilities a significant degree of autonomy could be an important means for local governments to improve technical efficiency and quality through more flexible hospital management. In Chile and Colombia this choice was not made at the local government level but rather determined by national policy. In Chile, the hospitals were not devolved to municipal governments and therefore the municipalities had no choice over their organization. In Colombia, national policy required the creation of autonomous public entities (ESE) and offered municipalities little choice over this decision. In Bolivia, local hospitals were granted different degrees of autonomy by the local authorities, with little guidance from the national government.

In some countries—such as the Philippines—local governments are allowed to create or sponsor social insurance schemes. In none of the cases we studied was this authority allowed at the municipal level.

A tool of local management for manipulating local incentives is the ability to determine the means of payment to local providers. In Chile, municipalities were first allowed to pay their staffs and contractors by any means allowed under the commercial code, until the Human Resources Statute restored the salary mechanism for primary care personnel. In Colombia, certified municipalities are allowed to pay salaries and bonuses although this choice is restricted by union agreements at the national level. In Bolivia, the municipalities did not have jurisdiction over civil service salaries and were not expected to provide bonuses. They did have authority to pay contract workers under the municipal code.

A major tool used by the central authorities to control local choice is the ability of the Ministry of Health to define the norms and standards of service and of special programs. These norms can be quite general sets of priorities or they can specify assignment of personnel, infrastructure, equipment and supplies to specific tasks and priorities. In Chile and Colombia, the Ministry exercised considerable control through well-defined and detailed norms and standards. In Bolivia, the Ministry's inability to disseminate and enforce norms and standards limited its control over local choice, initially allowing a greater range of choice in that country. However, with the implementation of the Maternal and Child Health Insurance, there was an effort to define and disseminate more standards in Bolivia, restricting local choice.

HUMAN RESOURCE FUNCTIONS

Local control over human resources may be a major means of improving the technical efficiency and quality of service. If local managers have more control over their staff, can provide appropriate incentives, hire and fire, they may be able to improve the services considerably. This capacity, however, may be limited by local pressures to provide patronage employment rather than hire the most appropriate staff. Chile initially allowed the greatest range of municipal choice over determining salaries and removed the primary health care staff from national civil service protections. This choice was severely restricted by the Human Resources Statute, which reestablished many of the civil service protections and restored a nationally defined salary range. In Bolivia and Colombia, local governments were given no control over local salaries or civil service staffing. Higher authorities controlled salaries, hiring and firing. However, in all three countries, municipal governments could contract additional health staff, within some restrictions.

ACCESS RULES AND LOCAL GOVERNANCE FUNCTIONS

Access rules for targeting might affect how local authorities assign resources to the poor in their communities. If they are allowed significant choice on this, some communities might innovate and find new means of targeting the poor while others may make no effort to target their resources toward the poor and needy. While Bolivia granted moderate choice over local targeting before the Maternal and Child Health Insurance, this act specifically targeted local resources to mothers and children. In Chile and Colombia, national policies established access and targeting and local governments had no choice.

Local governance is also a means of assessing the range of local influence on health systems. If local governments are elected there is a greater potential for local choices to be in concert with local popular preferences. In Chile the local mayors were initially appointed by the military government, however, after 1989 mayors were elected as they were throughout the study period in Colombia and Bolivia. Local authorities also had some choice in Chile over how to organize their local health administration and local facility boards -- were three organizational options from which a municipality could choose. However, in Bolivia and Colombia, the organizational requirements for these governance instances were defined by national law.

Choice about community participation was left to the municipalities in Colombia and Chile. In Bolivia, the Law of Popular Participation defined an active role for the community organizations (OTBs and NGOs) without allowing municipal choice over the forms.

ANNEX II. BLANK MAP OF DECISION SPACE

Functions	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of Revenue			
Expenditures			
Income from Fees			
Service Organization			
Hospital Autonomy			
Insurance Plans			
Payment Mechanisms			
Required Programs & Norms			
Vertical programs, Supplies and Logistics			
Human Resources			
Salaries			
Contracts			
Civil Service			
Access Rules			
Targeting			
Governance Rules			
Local Accountability			
Facility Boards			
Health Offices			
Community Participation			
Total Decision Space			

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